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Suicide Gatekeeper Training for Mental Health Professionals and Paraprofessionals as a Community based Prevention Strategy

Andrew Guilfoyle
Edith Cowan University

Suicide gatekeeper training for mental health professionals and paraprofessionals as a community based prevention strategy

Dr Andrew Guilfoyle

SCHOOL OF PSYCHOLOGY AND SOCIAL SCIENCE

- *You're better off to know what to do than not know what to do*

acknowledgement

- **Presentation based on**

- Guilfoyle, A. M., (2009). *A Spider in the Web*: *Evaluation of Phase 2 of the Understanding & Building Resilience in the South West Project*, Report to *Commonwealth of Australia, Department of Health and Aging.*

- Guilfoyle, A**.,** & Taylor, M. (in preparation). Regional community based suicide prevention through Gatekeeper workshops for professionals and paraprofessionals.

Related research

- Botha, K-J, Guilfoyle, A. M., Botha, D. (2009). Beyond normal grief: A critical reflection on immediate post-death experiences of survivors of suicide, *Australian e-Journal for the Advancement of Mental Health (AeJAMH), 8(1*), 1-10.
- Guilfoyle, A., & Evans, T., & Taylor , M. (in preparation). Young adults' experiences of how community-based interventions can promote their resilience to suicide.
- Guilfoyle, A., Taylor, M., & Welsh, H. (2010). Exploring School Counsellor's/Psychologist's Experiences of Building Youth Resilience: A Regional Community's Perspective

Evolution of project

- In January 2003, the South West Area Health Service (SWAHS) – Population Health Unit researched the issue of suicide in the South West

- a briefing paper to the Chief Executive Officer of SWAMS.

- absence of a regional, across-population body
- communities and agencies have had diverse but restricted outlets for action due to limited resources and coordination gaps.

- The major recommendation to develop a regional process of coordination, collaboration and working in partnerships to reduce risk factors and increase protective factors for suicide prevention in the South West.

Phase 1: Road Maps

Town	Total Community Participants	Total Service Provider Participants	Number of Focus Group Interviews	Number of Individual Interviews
Bunbury	35	39	10	25
Busselton	11	34	6	9
Collie	18	8	4	5
Bridgetown-Greenbushes	28	13	6	0
Manjimup	21	17	5	2
Margaret River	21	8	4	1
Nyungar communities	45		3	
TOTAL	**179**	**119**	**38**	**42**

Road maps

- An evidence-based and community endorsed Report, which has identified service gaps, and ways in which to build community resilience and reduce risk factors for suicide in the region.

- Costello, D., Johns, M., Scott, H., & Guilfoyle, A. M**.** (2006). Southwest Suicide Prevention Project: Understanding and Building Resilience. Report to *Commonwealth of Australia, Department of Health and Aging.*

Phase 2: Implementation

- Project Officers
- *You need a spider in the web or otherwise there won't be a web.*
- Local Working Group in each community to promote community resilience
- To include key agencies and interested community members
- Identification of a lead agency and/ or coordinator
- Prioritise issues and develop an action plan
- 3 years

Example Organisations in Sampling Frame

Education Department
Henri Nouwen House
Department for Community Development
Office for Children and Youth
LAMP Inc.
Town based Community Members
Department of Veterans Affairs
Disability Services Commission
Agencies for SW Accommodation
City of Bunbury
Non Government Schools Psychology Service
WACHS-SW
Department of Education and Training
Department for Child Protection
Milligan House
Police Department
Mission Australia
Uniting Care West

SW Community Drug Service
Edith Cowan University (student group)
Advocacy South West
Mental Health Consumer and Advisory Group
Investing in Our Youth
Red Cross
Manjimup Volunteer Resource Centre
Manjimup Family Centre
South West Counselling
Warren Blackwood Emergency Accommodation
Youth Focus
Anglican Church
Collie Family Centre
Waratah
Vasse Leeuwin Mental Health Service
TAFE (student)
MATES Service
Other

Example Organisations in Sampling Frame

Cancer Council WA	Department for Education and Training
Retail	Val Lishman Foundation
Electoral Office	Gay & Lesbian Community Services
Jobs South West	Uniting Care West
Investing in Our Youth	LAMP Inc
TAFE	Bridgetown Times
Mission Australia	Donnybrook Bridgetown Mail
Bunbury Pathways ‘92	DOVES
SW Respite	Community Health
WACHS-SW	MVRC
Lifeline WA	Health Department
Mentally Healthy WA	SWAMS
Collie Shire	Aboriginal Healing Project
Manjimup Shire	Corrective Services
Bridgetown-Greenbushes Shire	Red Cross
Mindframe	Aboriginal Challenge Employment

Activity

Mentally Healthy WA Project – Act Belong Commit
Preventing Suicide information pamphlet
Promotion of project in local papers, newsletters
Reformatting community directories
Rotary Community Health Forum
Information packs, Welcome packs and posters
Lifeline WA Education Package – "Building a Suicide Safe South West"
South West Mental Health Network
Southern Forest Transport Strategy Forum

Collaboration with SW Mental Health and other service providers
Mental Health Week
Participation in NAIDOC activities
Facilitated access to REDRESS
Partnership with Jobs South West
Aboriginal Camps in partnership with Waratah Aboriginal Healing
Research Project Advisory Group
Collaboration with City of Bunbury Community Safety & Crime Prevention Committee
Healthy Truck Stop

Education/training

- broad scale training activities of the project identified as a critical need in Phase 1.
- Became a key focus of Phase 2.
- A range of training courses, presentations and workshops were organised and made available at a community, paraprofessional and professional level.
- **Objectives:**
- *To everyone and they were open to everyone and they were acceptable and they were free*
- Build sustainability of outcomes through these educative initiatives

Training included

- Mindframe Workshops
- Gatekeeper Training
- Open Closets and True Colours Training
- LAMP Inc Psycho Educational Training
- Andrew Fuller Barrier Busters Tour
- Pitstop Programme
- A Way Through Workshops / Map of Loss
- Aboriginal Cross Cultural Awareness Training
- Blokes Business Workshops (DOVES DV Education & Supprt Committee)
- Nexgen Workshops
- Maggie Dent Presentations
- Healthy Truck Stops
- Training ATSI Mental Health First Aid Instructors

Gatekeeper workshops

- Increasing recognition of the underlying need to improve through Professional Development training, the mental health literacy of individuals at the forefront of preventing suicide (Scott & Armson, 2000).
- individuals at risk of committing suicide rarely self-refer for help
- but frequently give off warning cues
- it is these cues that need to be picked up and acted upon by paraprofessional and referral can be made to an appropriate professional (Cross, Matthieu, Cerel & Know, 2007)

Objective:

- The provision of regular, ongoing Gatekeeper training to those personnel in organisations who provided assistance to high risk groups in an effort to increase their understanding of suicidal behaviour .

- tools to assess suicide risk and recognise and respond to people at risk of suicide and how to provide support to those who are suicidal.

- professionals: Psychologists…

- for use with paraprofessionals :
- chaplains, counsellors, health workers, nurses, police officers, school psychologists, social workers, teachers, youth workers
- key frontline stakeholders:
- Emergency department, carers; community volunteers, co-workers and employers

Workshop

- Worksop developed by the Western Australian Ministerial Council for Suicide Prevention
- The two-day Gatekeeper Suicide Prevention Training Workshop is comprised of a series of (12)modules
- Interactive, real life scenarios, empathetic listening etc.
- Delivered by an experienced registered Psychologist

items

I understand the social problem of suicide
I understand the level, patterns and trends of suicide in Australia and WA
I can name the risk and protective factors associated with suicidal behaviour
I can specify the mental disorders that are associated with suicidal behaviour
I am confident working with suicidal people
I know how to asses suicidal risk
I can accurately distinguish between self-harming and suicidal behaviour
I can respond appropriately to people who are suicidal
I am clear about my role working with suicidal people
I can name the behaviours and verbal expressions that may reflect suicidal ideation

I can describe the needs of the suicidal person, family/carers/community and the worker
I can demonstrate how to link and raise the issue of suicide with an at risk person
I can describe a comprehensive model (using an interview format) for assessing suicide risk
I can take appropriate actions based on my suicide risk assessment
I can apply a range of strategies to assist people at high risk of suicide
I know the consultation and referral process and options available
I can apply a number of strategies to assist a person at low risk of suicide
I can describe an effective response to a completed suicide

participation

- a series of 14
- two day workshops
- held locally, in schools, community halls etc
- Advertised through the agency website, local working group and through key stakeholder meetings
- Provided either free or at minimal cost.

  People who are most likely to benefit are less likely to be in a position to pay. Thus the provision of low or no cost sessions enabled more vulnerable populations to attend.
- delivered to 233 paraprofessionals
- Six Western Australian rural communities (Manjimup, Bridgetown, Collie, Margaret River, Bunbury, Busselton)

- *Also Gatekeeper Train-the Trainer + Advanced Gatekeeper + Three-hour workshop*

Attendees

Location	Workshops	Attendees	Other related workshops	Attendees
Bunbury	5	87	Gatekeeper Train-the Trainer	10
Busselton	4	65	Advanced Gatekeeper	15
Margaret River	1	15	Three-hour workshop *	17
Bridgetown	1	10		
Manjimup	1	17		
Collie	2	39		
TOTAL	**14**	**233**	**3**	**42**

Community participation

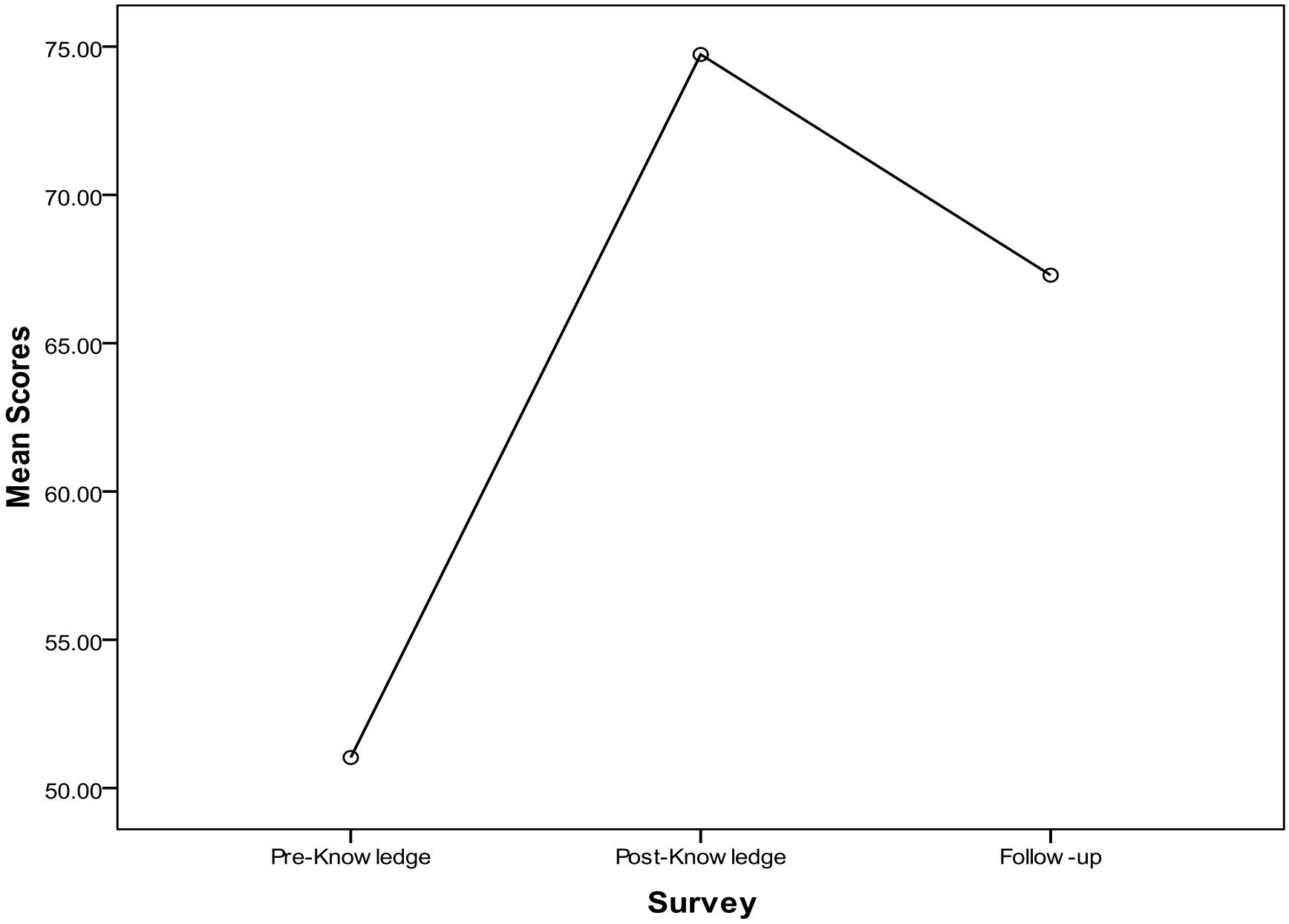
Gender	Male	32
	Female	180
	Unknown	13
Age	13-24 years	17
	25-44 years	105
	45-55 years	62
	55+ years	28
	Unknown	13
Culture	Australian	182
	Migrant	11
	Aboriginal	6
	Other	9
	Refugee	1
	Unknown	16

Service	Government	94
	Non-Government	87
	Other	15
	Unknown	29

Work	Nurse	44
	Programme Co-ordinator	9
	Youth Worker	13
	Support Worker	9
	Student	8
	Psychologist	19
	Counsellor	26
	Social Worker	8
	Chaplain	12
	Health Worker	41
	Carer	1
	Teacher	5
	Volunteer	2
	Other	16
	Unknown	12
Experience	1 year	41
	1-2 years	22
	2-5 years	44
	6-10 years	29
	>10 years	49
	Unknown	34

Triangulated data set

- A: 18 item self-report pre, post and follow-up questionnaire.
- 211 participant paraprofessionals completed the initial pre-workshop questionnaire;199 completed the post-workshop questionnaire.
- 41 completed the maintenance survey – emailed/mailed approximately 6-2 months after the workshop.
- B: qualitative data from five semi-structured questions added to the post and maintenance questionnaire.
- C: 15 follow-up interviews
- D: In addition 32 non attending project stakeholder interviews


75.00
70.00
65.00
60.00
55.00
50.00
Mean Scores
Pre-Know ledge
Post-Know ledge
Follow -up
Survey

Pre-workshop knowledge

- ANOVA/Pairwise comparisons (Tukey's HSD tests, *p*s<.05)

- Highest score: I understand the social problem of suicide; (*M* = 3.61, *SD* = .88).

- The two lowest scores:
- I can describe a comprehensive model … for assessing suicide risk; *M* = 2.12, *SD* = .97)
- I can describe an effective response to a completed suicide; *M* = 2.15, *SD* = .97).

- increase in scores on all statements between pre and post knowledge

Pre-Post and Follow-up knowledge

- Pairwise comparisons (Tukey's HSD tests, *p*s<.05)
- *knowledge significantly higher at follow-up than it was prior to the workshop.*
- exception of "I understand the social problem of suicide"
- *significant decrease between post-knowledge and follow-up scores.*
- For the majority of statements (1, 5, 6, 7, 8, 9, 12, 14, 15, 16 and 17) this reported decrease was not significant.

Pre-Post and Follow-up knowledge

- decrease of knowledge from post workshop for these statements

- *I understand the level, patterns and trends of suicide in Australia and WA*
- *I can name the risk and protective factors associated with suicidal behaviour*
- *I can specify the mental disorders that are associated with suicidal behaviour*
- *I can name the behaviours and verbal expressions that may reflect suicidal ideation*
- *I can describe the needs of the suicidal person, family/carers/community and the worker*
- *I can describe a comprehensive model (using an interview format) for assessing suicide risk*
- *I can describe an effective response to a completed suicide*

Qualitative questions

- *In general do you have any comments about the training you received and how it relates to preventing suicide or building resilience within your community?*
- *Have you applied what you learnt in the workshop to your role in helping to prevent suicide or in building resilience within your community?*
- *Any specific barriers for you in applying what you learnt from the workshop?*
- *Would you like any further training in suicide prevention?*
- *What training information would you like and how would you like this to be delivered?*

- *The interviews ask participants to expand on these:*

- How they understand resilience in this context and the connection between this and the activity (activities)

Achieved key reported objectives

- Training is designed to improve the individual's knowledge, attitudes and skills of identification of at risk individuals (Cross, Matthieu, Cerel & Know 2007).

- The aim the Gatekeeper Suicide Prevention Training Workshop Program is to provide paraprofessionals with the necessary identification, assessment and referral skills (Cross et al., 2007).

- Trained individuals can take their knowledge beyond the work setting into the community (e.g. family, friends and social networks).

Themes

- instrumental and relational aspects
- *Knowledge : specific + broad, assessments, identify, alert, follow up support, listening, ideas, suicidal person + family, community*
- *Confidence deal with incidents, communicate, sneak out, fear, courage, comfortable*
- *Economics*
- *Community bonding: bounded community, warmed people, culture of sharing, obligation,*
- *Taboo subject: misconceptions, first steps, call someone without fear, community awareness*
- *Connectedness, networking; putting people together,*
- *Social support: supportive environment, trust*
- *Shared awareness; have you tried that, spread to colleagues, referral services available, size of issue*

Themes

- *More targeted your approach*
- *Extend to everyday community*
- *Cultural aspects*
- *Critical factors, setting people up; babysitting all night*
- lack opportunity to apply them within their present work role
- still found the issue of suicide ideation too difficult to broach with their clients.
- lack of professional supervision as a barrier
- personal barrier – bounded community *Future training*
- *Cognation effect, aboriginal attitudes, self harm, mental health act*

I didn't feel comfortable

- *…talking to people in the community, they have had a family member or someone really close to them who has committed suicide the regret has been I know that there was something I knew and they said something…and I didn't know how to react so I laughed it off or I walked away or I did something else you know, but I didn't respond because I didn't feel comfortable to. So I think that absolutely that is the way to be doing it because obviously people in your life are the people who are accessing you very regularly you know.*

Critical factors

- *needs to be done very carefully especially in situations where there is not the backup services*
- *infrastructure very…close at hand (remoteness)*
- *duty bound*
- *What do they do with this person?" - ED department*
- *mental health is misnamed – not really equipped to pick up on subtle slip between depression;* insufficient time to develop the necessary level of rapport with clients that would allow them to implement the strategies
- *whose client are they?*
- *a very short space of time*
- systems *GPs often have a 3 or 4 week waiting list to discuss their mental health or suicidal idolisation. And what we promote in training is that people seek help now.*
- lack opportunity to apply them within their present work role

conclusions

- Asses role integrated within other project activities

- Facilitate inter-sectoral collaboration to develop and promote strategies for building community resilience;
- Build the capacity of local communities to address service gaps and access to existing services;
- Develop local strategies to facilitate opportunities for people to connect with their communities;
- Build the capacity of communities to recognise and respond appropriately to people at risk of suicide; and
- Build community capacity for help seeking behaviour by increasing awareness and knowledge of referral and support services

conclusions

- *You're better off to know what to do than not know what to do*

- Training

- increased people's awareness of specific issues
- their willingness to discuss the issue with others
- especially if the issue was one that was traditionally 'hidden' or associated with some level of stigma, such as suicide, mental illness, same sex attraction or domestic violence.
- successful in providing education and skills development to all community members
- an effective vehicle for building the capacity of individuals and organisations to care for themselves and to support others in the community.

system of relations

- If one can imagine that the effects of one person's action radiate with equal force in all directions through networks they're in contact with, then in principle an action has implications for an indefinitely large system of relations and a vast number of people
- (Nespor & Groenke, 2000, p. 998-999).

knowledge

- a) individuals experiencing suicidal thoughts or engaging in self-harm
- *easy to use* suicide risk assessment tool and practical intervention strategies.
- *easy to use* suicide risk assessment tool and practical intervention strategies.
- *more alert to at-risk people*
- better able to identify suicidal intent and detect warning signs
- *listening skills*
- *how to offer follow-up support*
- *it actually just opens up your own ideas on, "Wow, I hadn't even thought about approaching it in that way."*

- b) people affected (e.g., family member, friends, work-colleagues)

confidence

- sufficient confidence to deal with incidents of suicide ideation or attempt
- more effectively communicate with the individual's suicide/harming actions.
- *able to speak out knowledgeably on the topics of suicide and self harm*
- *much more comfortable with discussing suicide and no longer try to avoid or skim over the subject*

- *…that feeling you know there is that fear of like if I raise it as an issue I might somehow put the idea in someone's head*

- *It's given me the courage to ask further questions, to see whether they are feeling suicidal and it has given me a lot more knowledge of the things to look for*

I didn't feel comfortable

- *…talking to people in the community, they have had a family member or someone really close to them who has committed suicide the regret has been I know that there was something I knew and they said something…and I didn't know how to react so I laughed it off or I walked away or I did something else you know, but I didn't respond because I didn't feel comfortable to. So I think that absolutely that is the way to be doing it because obviously people in your life are the people who are accessing you very regularly you know.*

Bounded community

- Local – economics
- *people warmed to delivering a service that was useful but at no cost*
- *Bounded community*
- *where everyone knows everyone'* a 'strong *culture of sharing*' .
- Hence, "*sharing information with other youth workers that haven't been able to attend the course'*
- *"It is not so much an attendance obligation, but rather an engrained facet of rural life".*

Taboo subject

- *make the first step to make contact without being obtrusive...*
- a non-biased stance when they conducted a risk-assessment/ *not be judgmental*
- *watch my assumptions* - dispelling some of their previously held misconceptions
- *I think that bringing it out in the opening they are able to pick up a phone and call somebody or speak to somebody whereas before there was maybe that stigma attached and people were a little bit silent about it. So that freedom to be able to talk about it certainly helps.*
- *created a lot of community awareness and a lot of community skills in terms of their understanding about suicide. I also think that it's provided a better understanding of most aspects associated with suicide. It's not a taboo subject which was certainly the community perception that was widely thought out there.*

connectedness

- *suicide prevention begins, at the proper preventable level, by establishing better connections in communities and then suicide prevention will flow on from that.*

- *…what I have observed in the training is that by putting people together for the two days, that has established a sense of connectedness between those providers so that they know better how to call upon themselves…and I think that is such a valuable part of people learning how other services work or how other people work and they learn from one another…. I think this adds something especially in smaller communities outside the metro because they rely on each other so much more.*

Social support

- *I now network with people. I get help from my colleagues and take that knowledge and share it with (other) colleagues.*

- *But a common thread is that it is supportive...everyone is there and even to have the mind retriggered on a concept of something you might be able to do or "remember this came up in the training, do you think if you tried that."*

Shared awareness

- size of the task as being *'huge the (knowledge) gap out there'.*
- They revealed that in their experience *'young people don't know the services that are available to them'*
- they now felt it was their responsibility to *'promote those services that are available'.*

- *I think there are more organisations who are aware of their responsibilities now in terms of dealing with people who have suicidal issues or for others realising that they don't have to deal with it just themselves.....*

- *Increasing awareness of referral and support services - you assume in a small town people would actually know where to go for help*

more targeted your approach

- targeted to those who could put into practice what they learnt either in their own agencies or services.

- *…you start thinking around how it can be embedded in part of your own assessments or discussions….*

- *the more targeted your approach, and GPs are usually seen as the top of the tree, the more targeted your approach, in a sense the more highly skilled people, the better evidence there is that it actually makes a difference in terms of suicide prevention.*

Extend to everyday community

- Extend to community – or keep to paraprofessionals

- *they feel more valued and they're probably not suicidal by the time they are assessed. So they are sent home. Yet the person who has been with them has been through that experience with them of having seen them when they are suicidal*

- *They wouldn't have to necessarily be paid workers but I guess more than mums and dads and interested community workers. More people who work in a capacity, either voluntary or paid, where they come into contact with suicidal people and need to pick up on warning signs.*

community members armed

- *And the reality is I think if you look at the statistics it's about 90% of the people who actually commit suicide are people who are not in counselling service provision. You know they haven't actually sought help or been to see someone, and the reality is the others are out there in the community so it's the community members that need to be armed.*

- *How are you going to offer the education to the people that aren't going to come to those sessions because it seems to be a very middle class thing to come along to a session and the education talk.*

- Evans, T., Guilfoyle, A., & Taylor , M. (in preparation). Young adults' experiences of how community-based interventions can promote their resilience to suicide.

Cultural aspects

- *[the training going into the community was also an advantage] …because you've got lots of issues. You've got transport issues. You've got vacancy issues. You've got family issues. You've got issues where they don't want to be in the room with somebody else, but the other person can attend another workshop somewhere else….*

- *...for the Aboriginal community…the Gatekeeper, we had a lot of stress about that because it wasn't culturally appropriate.*

- The developments of alternative training such as A Way Through (see below) offered a different form of training to meet the needs of Aboriginal communities.

No services/supports as back up

- *… there's an interesting relationship, that the more awareness you create the more people have some level of capacity to respond and then they've got to have these services there to back them up if they're noticing someone who's struggling in some way or something like that you've got to have somewhere to go with that.*

- *[re consequences of training] It really is setting people up in a big way. Basically what happens the people who have most got their act together in a local community wind up being so swamped that they end up getting pulled down and don't have anything left at the end of the day. That's just not fair. But we need a massively greater commitment to doing something than we have at the moment....*
- Guilfoyle, A., Taylor, M., & Welsh, H. (2010). Exploring School Counsellor's/Psychologist's Experiences of Building Youth Resilience: A Regional Community's Perspective

babysitting all night

- *the last time that it happened, ...we ended up taking this person to an auntie ...who was an older woman as well. And we're going driving off going, "Frigging hell! You know if he actually topped himself through the night, like that poor family, that poor auntie, and us like you know, cos we just left him there."*

- *...the hospital says well we don't have the staff or the beds you know 'cos we'd need someone to watch them 'cos if they harmed themselves while they're here then we're in trouble you know. And so it's like, "See you later!" So now they go, "Well what the bloody hell do we do then?" It's like walking out with people going, "Oh crap! We're going to be babysitting all night!"*

Future training

- *I don't think you can ever say, "We're all skilled up. We're all the full boot." No, definitely it's an ongoing thing. I learn something every time I go to a session….more we know, the more we understand…that can only be a good thing because then when we go to work ….we're doing al the right things.*

- *the contagion effect of self harm*
- *aboriginal attitudes towards suicide/self harm*
- *strategies you can offer individuals who are at high risk of deliberate self harm and experimental self harming,*
- *the Mental Health Act*

mental health is misnamed

- *And also the other problem is that I think mental health is misnamed in that mental health providers like the Health Department is actually an organisation that is funded to provide support to people with acute psychiatric condition or chronic long-term psychiatric illness that requires on-going support. Now someone who has a mild to moderate depression with aspects of suicidal idolisation and may slip quickly into quite a severe depressive state and become suicidal quickly is probably not necessarily picked up by people in mental health as being warranted as being a client of theirs in that early stage. So while they have mild to moderate depression they consider them not their client.*

Remote areas

- *And the other problem is that our GPs often have a 3 or 4 week waiting list. So if the person goes to their GP they have to wait 3 weeks to discuss their mental health or suicidal idolisation. And what we promote in training is that people seek help now. So the system isn't really set up to accept the response of that.*

- *In some of the more remote areas and more isolated areas, I think that's always going to be the challenge simply because knowing something and then having an infrastructure very close at hand that's going to support what you need is difficult.*

it can take you six visits

- *I believe that someone who has done Gatekeeper training probably has more skills and ability to understand someone who is suicidal than a GP....They spend five weeks I think looking at issues around mental health and unless they do some special training in it, they are not equipped to deal with those people in my view at all....and they don't have the time. I mean it can take you six visits to get somebody to bloody open up and talk to you...If you take a person who is in a state of,....they may not be severely depressed, but they're mildly depressed, moderately depressed, the issues that they've got, they're usually being fed by the fact that they're a little bit paranoid or a little bit untrusting of the world and they have received a few knocks. And it might not be until...you have seen them several times that they develop enough trust to actually talk to you and some of these people in the marginalised groups have been through every mill under the sun so they're not going to be trusting of anybody.*

what to do with, these people next

- *A major component of the training is that they become more aware of how they can identify, but also that they become more aware and knowledgeable of what to do with, these people next – who to contact, how to assist them in the first instance, where to refer to, all those types of things…and not being afraid of talking about suicides if they have concerns. We always say that if the one message that we get across is that people can mention that word and ask people if they are having thoughts of killing themselves or of self-harm, that would be a major asset….There is a lot of hesitancy to do that , obviously with lay people, but no less with professionals.*

infrastructure very…close at hand

- *... knowing something and then having an infrastructure very…close at hand that's going to support what you need is difficult. once you've given out the information actually having things in and around the community that can support you. So if they say someone is at risk you can take them to this support centre, but if you don't have a support centre or if you don't have a counselling centre especially one that's been trained in suicide and at risk, then do you say, "Of course you can go to Bunbury or you can go to Perth?" So again, you're putting that pressure on the person or the family to make these long pilgrimages.*

duty bound

- *…we have done a lot of work in building people's understanding and education and requesting that people get some help…. but the system isn't really set up to accept the response of that…When you have someone who is suicidal it might be a very short space of time that that person is in critical mind set of that and by the time you get them to hospital and wait for 5 hours they are probably over it because you have spent 5 hours with that person and they feel more valued and they're probably not suicidal by the time they are assessed. So they are sent home. Yet the person who has been with them have been through that experience with them of having seen them when they are suicidal and knowing that they will be suicidal again and being concerned about leaving that person on their own which is duty bound rightly so.*

”What do they do with this person?”

- *It’s the after-hours referrals though isn’t it that is the service gap? And I think all organisations are facing that. Certainly from the youth sector the strong feedback is around you know you’re only option....was to take them to the ED department and when they get them to ED department they often send them home. So then they’re facing the issue ... ”What do they do with this person?” You can’t just leave them on their own, under a duty of care. They can’t take them to hospital. Where do they go....When you’ve got someone at nine o’clock at night and the hospital won’t take them, they’re not from Bunbury. You know it’s very hard and what do you do? You can’t just let them out on the side of the road. It’s a massive issue.*